-PATIENT CONFIDENTIAL INFORMATION

1. Name _____
First Middle Last

2. Address _____
Street City State Zip

3. Home Phone _____ 4. Business Phone _____

5. Fax _____ 6. Email _____

7. Age _____ 8. Date of Birth _____ 9. Sex _____ 10. Marital: M S D W

11. Social Security No _____ 12. Driver's License No _____

13. Occupation _____ 14. Employer _____

15. Employer's Address _____
Street City St . Zip

16. Preferred method of contact _____
Phone call Text Email Other.

CASE HISTORY

17. Have you seen any other doctor about this condition? _____ If yes, when? _____

Doctor's Name _____ Address _____

18. Have you had recent X-Rays? _____ If yes, when? _____ Area X-Rayed _____

19. Spouse's name _____ Occupation _____

Employer _____ Address _____ Phone _____

20. Nearest relative not living with you _____

Address _____ Phone _____
Street City State Zip

21. In case of emergency, call
Name Street City Phone

FOR FEMALES: Are you pregnant? _____ IF YES, HOW LONG? _____

FOR MINORS: List both parents' names and addresses

_____

_____

FINANCIAL ARRANGEMENTS

How do you plan to handle your account? (Check one) ☐ Cash ☐ Check ☐ Master Card ☐ Visa

INSURANCE INFORMATION

Do you have a personal, group health or accident insurance? _____ If yes, give: _____

Company Name _____ Address _____

Subscriber Name _____ Group Number _____

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint.

DATED _____ PATIENT'S SIGNATURE _____
(parent's signature if patient is minor)

Referred by _____